Claim for Compensation by Widow, Widower, and/or Children

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0155
Expires: 03-31-92

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number
GOODE, Jason B.	6-2-57	1-27-95	2-1-95	999 88 7777

6. Name and address of employing agency (Include zip code)
DFAS-CO-HR
Columbus, OH 43218-2317

7. Nature of injury which caused death
Massive head trauma incurred in vehicle accident while TDY.

Claim of Surviving Husband or Wife (Items 8 through 13)

8. Name and address (Include Zip Code)
Mrs. Mary I. Goode
100 Boylston Avenue
Newark, OH 43055

9. Your Date of Birth (Mo., day, year): 1-5-60

10. Date of Marriage to Employee (Mo., day, year): 6-15-80

11. Were you living with the employee at time of death? ☒ Yes ☐ No

12. Were you ever married to anyone other than the employee? ☐ Yes ☒ No

13. Was employee ever married to anyone other than yourself? ☐ Yes ☒ No

14. List all of employee's children from this marriage who may be entitled to compensation (See attached information sheet for definition of children):

Name	Relationship	Date of Birth	Address (Include Zip Code)
Mary Lou	Daughter	1-14-84	Same As Item #8
John Jason	Son	7-1-86	Same As Item #8

14a. List all of employee's children from prior marriages who may be entitled to compensation:

Name	Relationship	Date of Birth	Address (Include Zip Code)
None			

15. If a legal guardian has been appointed for any child named above, give name of child, name and address of the guardian.

Child	Guardian	Guardian's Address (Include Zip Code)
None		

16. List other relatives who were fully or partially dependent on employee:

Name	Relationship	Date of Birth	Address (Include Zip Code)
None			

17. If employee was ever in the Armed Forces of the United States, give:
Service number: N/A
Branch of service:
Period of service:

18. If application has been made for Veterans Administration (VA) benefits because of employee's death, give:
VA Claim number: N/A
Address of VA office where claim is filed:

19. If application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give:
Claim Number: Claim filed 2-7-95.
Date Annuity began:
Amount paid per month: $

20. If a claim has been made against a third party because of employee's death, give:
Amount of recovery: $ N/A
Name and address of third party:

21. Total burial expense: $ 8,500

22. Amount of burial expense paid or payable by VA: $ None

23. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid: Mary I. Goode $ 8,500

I hereby certify that each and every statement made above is true to the best of my knowledge.

24. Signature of person filing claim: Mary I. Goode

25. Address (Include Zip code)
100 Boylston Ave.
Newark, OH 43055

26. Date (Mo., day, year): 2-7-95

Form CA-5
Rev. Mar. 1989

Figure 810-13. Claim for Compensation by Widow/Widower, and or Children.

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)	2. Date of death (Mo., day, year)

3. What history of injury or employment related disease was given to you?	4. If treated for disease, give diagnosis.

5. If death was not instantaneous, describe the treatment you provided.	6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? Give the medical reasons for your opinion, unless causal relationship is obvious. ☐ Yes ☐ No

10. Was a biopsy or an autopsy performed? ☐ Yes ☐ No
If yes, give name and address of physician and arrange for a copy of the report to be submitted.

11. Name and address (Please type - include Zip Code)	12. Signature	13. Date signed (Mo., day, year)

GPO : 1992 O - 325-858

Figure 810-13 Continued

INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

Who Should File Claim	• This claim form should be completed and filed by the widow or widower for self and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim.
When Should Claim Be Filed	• Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	• The marriage certificate(s) for a widow or widower; death certificate for decedent if not previously submitted; birth certificate or adoption documents for each child. Also, if appropriate, Letter of Guardianship. If either the decedent or the surviving spouse was previously married, legal documents showing dissolution of such prior marriage(s). Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	• All items should be completed. If an item is not applicable, indicate by showing "NA". Note that the form requests information about several different categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-13 the surviving widow or widower; 14-14a, surviving children; and 15, the children's guardian. The attending physician's report on the reverse of the claim must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	• Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

Form CA-5
Rev. Mar. 1989

Figure 810-13 Continued

DEATH BENEFITS FOR SURVIVING WIDOW, WIDOWER AND/OR CHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Widow or Widower	• To qualify for benefits, a widow or widower must have been living with the employee or separated for reasonable cause prior to the time of death. Payments continue for life or until remarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 60 or later, no lump sum is paid. Instead, payments continue for life.
Children	• Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate on: marriage, completion of four years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	• For widows or widowers - 50% of the employee's monthly pay if there are no surviving eligible children - 45% if there are eligible children. Children - 15% each, not to exceed a total of 30%, shared equally if there is a widow or widower; if there is no widow or widower, 40% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS-15 of the General Schedule.
Funeral/Burial Allowance	• Funeral and burial expenses up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	• If the injury or death results from activity of a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

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Washington, D.C. 20402

Figure 810-13 Continued

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DoD 1400.25-M

Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0155
Expires: 03-31-92

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number
Sperry, Norton C.	10-01-64	12-10-93		555 44 3333

6. Name and address of employing agency (Include zip code)	7. Nature of injury which caused death
Elmendorf Commissary DECA/NW-DP-ELM, Elmendorf AFB, AK 99506	Massive internal injuries incurred in auto accident

8. Name of dependent (Last, first, middle)	9. Dependent's address (Include zip code)	10. Dependent's birth date (Mo., day, year)
Sperry, Linda M.	110 Hunter Avenue Anchorage, AK 99501	12-01-24

11. Dependent's Occupation	12. Dependent's Social Security Number	13. Dependent's relationship to employee	14. Extent of dependency on employee
None	100-20-3000	Mother	[X] Total [ ] Partial

15. Total amount employee contributed to dependent's support during 12 months immediately prior to death.	16. Did employee live with dependent during the 12 months immediately prior to death?	17. Total amount employee paid dependent in money or service for room and board in addition to amount shown in 15.	18. If no fixed amount was paid for room and board, what is the fair value of such room and board?
$ 6,000.00	[X] Yes [ ] No If "Yes", Complete 17 & 18.	$ None Per ____	$ 2,000.00 Per year

19. If dependent was employed during 12 month period prior to employee's death, give:
- Type of work performed:
- Period of employment: Was not employed
- Monthly pay rate:
- Name and address of employer:

20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:

Investments	$ - 0 -
Pensions	4,000.00
Persons other than employee	- 0 -
Other	- 0 -
Total	$4,000.00

Information about dependent's husband or wife (Items 21 through 25) Widow

21. Birth Date (Mo., day, year)	22. Occupation	23. Monthly pay rate	24. Total income from all sources for 12 months prior to employee's death.
		$	$

25. List all property owned by dependent and husband or wife (omit clothing, furniture, personal items).

Description	Date Acquired	Value
None		

26. If employee was ever in the Armed Forces of the United States, give:
- Service number: N/A
- Branch of service:
- Period of service:

27. If an application has been made for Veterans Administration (VA) benefits because of employee's death, give:
- VA Claim number: N/A
- Address of VA office where claim is filed:

28. If an application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give:
- Claim Number: N/A
- Date Annuity began:
- Amount paid per month: $

29. If a claim has been made against a third party because of employee's death, give:
- Amount of recovery: $ Pending
- Name and address of third party: Black's Produce Co.
  66 Pinewood
  Anchorage, AK 99500

30. Total burial expense	31. Amount of burial expense paid or payable by VA	32. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid:
$ 6,500.00	$ None	Linda Perry Same As Above $ 6,500.00

I hereby certify that each and every statement made above is true to the best of my knowledge. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

33. Signature of person filing claim	34. Address (Include Zip code)	35. Date (Mo., day, year)
Linda M. Sperry	110 Hunter Ave Anchorage, AK 99501	01-04-94

Figure 810-14. CA-5b "Claim for Compensation by Parents, Brothrs, Sisters Grandparents, or Grandchildren"

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)

2. Date of death (Mo., day, year)

3. What history of injury or employment related disease was given to you?

4. If treated for disease, give diagnosis.

5. If death was not instantaneous, describe the treatment you provided.

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? Give the medical reasons for your opinion, unless causal relationship is obvious. ☐ Yes ☐ No

10. Was a biopsy or an autopsy performed? Arrange for a copy of the report to be submitted. ☐ Yes ☐ No

11. Name and address (Please type - include Zip Code)

I certify that all statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any knowingly false or misleading statement or concealment of material fact may subject me to felony criminal prosecution.

12. Signature

13. Date signed (Mo., day, year)

Figure 810-14. CA-5b "Claim for Compensation by Parents, Brothrs, Sisters, Grandparents, or Grandchildren"

INSTRUCTIONS FOR COMPLETING FORM CA-5b, CLAIM FOR COMPENSATION BY PARENTS, BROTHERS, SISTERS, GRANDPARENTS OR GRANDCHILDREN

Who Should File Claim	This claim form should be completed and filed by the deceased employee's parents, grandparents or representative (custodian or guardian) of minor brothers, sisters or grandchildren. A separate form is required for each person claiming benefits.
When Should Claim Be Filed	Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	The birth certificate of the deceased employee; also a death certificate if not previously submitted; birth certificates for minor brothers, sisters and grandchildren. If claim is made on behalf of a grandparent, birth certificate of decedent's mother or father, as appropriate. If claim is made on behalf of a grandchild, birth certificate of decedent's son or daughter as appropriate. Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	All items on the claim form should be completed. If an item is not applicable, indicate by showing "NA". Note that the claim form requests information about several categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-20 the dependent; 21-25 the dependent's husband or wife, if married at the time of employee's death. The attending physician's report on the reverse of the form must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

Figure 810-14 Continued

DEATH BENEFITS FOR PARENTS, BROTHERS, SISTERS, GRANDPARENTS AND GRANDCHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Eligible Dependents	• Benefits are payable on behalf of partially or totally dependent parents, brothers, sisters, grandparents and grandchildren.
Period Of Entitlement	• Parents and grandparents: Payments continue until death, remarriage or termination of dependency. Minor brothers, sisters and grandchildren: Payments continue until death, marriage or attainment of 18 years of age. Payments may continue beyond 18 if the child is mentally or physically incapable of self-support or is a "full-time" student. Student benefits terminate on: marriage, completion of 4 years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	• For parent - 25% of the employee's monthly pay, if one is wholly dependent and the other is not dependent at all. If both are wholly dependent - 20% each. A proportionate amount is paid if either or both are partially dependent. Brothers, sisters, grandparents, and grandchildren - 20% if only one is wholly dependent. If more than one is wholly dependent - 30% shared equally. If one or more is partially dependent - 10% shared equally if more than one.
Payment Priorities	• Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly salary or 75% of the top step of GS-15 of the General Schedule. The surviving widow or widower and children have first priority. Other eligible dependents may receive payment only if the widow or widower and children's percentages are less than 75%.
Funeral/Burial Allowance	• Funeral and burial expense up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	• If the employee's death was caused by a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Form CA-5b
Rev. Mar. 1989

Figure 810-14 Continued